

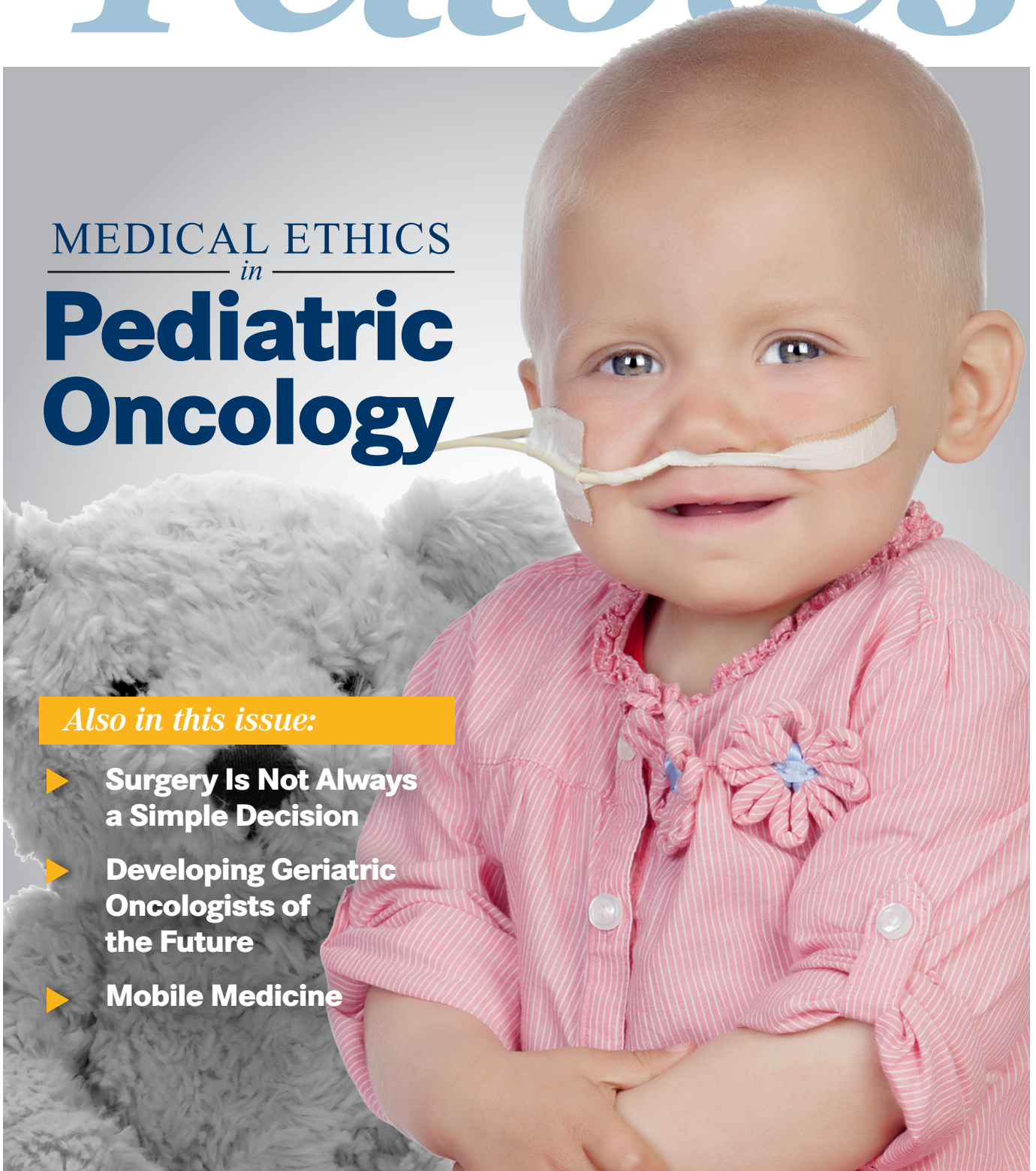
# Fellows

MEDICAL ETHICS  
*in*

## Pediatric Oncology

*Also in this issue:*

- ▶ **Surgery Is Not Always a Simple Decision**
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2 Clarke Drive  
Suite 100  
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If you'd like to submit an article for consideration in an upcoming issue, please e-mail Ariela Katz at akatz@onclive.com.



# MEDICAL ETHICS *in* **Pediatric Oncology**

*By Nitya A. Narayan, MD*

**“F**irst, do no harm.” This Hippocratic Oath is practically the initial we hear when we graduate from medical school and are set loose on patients as real doctors. In fairness, I think it hits very few people in that moment what that oath is about. You think you know what you’re saying—you certainly don’t plan to hurt anyone, and you are hoping to help many. In my case, as an oncologist and hematologist, I am focusing specifically on helping children.

On my last 10 days ever on the inpatient service (as a trainee), and after 4 years of medical school, 3 years of residency, and 3 more years of fellowship, I still often don’t know the right answer. Medical ethics are so complicated. We are a team of attending doctors, experienced nurse practitioners, fellows, residents, and medical students. We teach medicine, we learn, we make rounds, we examine patients, we place orders, and we ask for help when we don’t know the answer—sometimes from the pharmacist, other times from the research personnel, sometimes from the social worker, or sometimes from another specialist. »

## A WORD FROM YOUR FELLOWS

Everyone, at every level, is checking, rechecking, thinking, researching, asking questions, discussing, analyzing, and trying to help patients. We go home and read, we contact world experts, we search through the latest medical literature to see what is available; we try as hard as we can. We work in shifts so there is never a drop in momentum—sometimes 12 hours or sometimes a week. It depends.

What do you do when you have the best mentor and cutting-edge therapy, and yet nothing you do is working? The cancer and all its associated illnesses are leaving people literally broken, in multiorgan failure, with rare but very deadly syndromes and with rapidly enlarging tumor burden. You have to make decisions with your teams, both quickly and correctly.

What's the right thing to do when you know, medically, nothing short of a miracle is going to heal this

person? “Do no harm.” Is it more unethical to not offer something that is medically available when the family is willing to try anything, because you do not think it will work (and no one has ever survived the treatment)?

Sometimes these ethical dilemmas seem like they have an “of course” answer to them. The answer is easy if it is well researched and people know the benefits and the risks and aren't just making decisions based on desperation. But what if it's an experimental drug? It has worked in “10% of rats,” and the adverse events can kill your patient much

faster than their disease. Do you roll the dice then? “Do no harm.”

Maybe the ethical thing to do is to help a family understand when it is time to focus on the quality time that is left available rather than try to offer something that will likely not work for various reasons and achieve what is, unfortunately, medically impos-

sible. The patient (in this case the child) is suffering, sometimes consciously, with issues such as severe pain and difficulty breathing.

Just recently, one of our little angels who went to heaven was literally gasping for each breath in her final few days because of her tumor-filled lungs. However, she wanted to fight. “I'm not worried about myself, but I don't want to leave my mom behind,” she said. “Are you saying there is nothing else you can give me so she'll have more time with me?”

And sometimes, even when the patient is no longer conscious, the next ethical issue becomes, “In the midst of trying to help this person, am I doing things for them or to them?”

You overhear one supervising (well-intentioned) doctor make a decision to try yet another drug, and you see the sadness on the training residents' faces as they look down and shake their heads because they feel it's the wrong thing to do. Along with the dedicated bedside nurses, they're the ones who spend day and night in the hospital trying to bring comfort to the patient and their family.

Who is right? The person with the expertise who thinks, “This could work,” and wants to give the patient another shot—or the person who has watched all the suffering and wants to stop prolonging what everyone knows, in their gut, is the end of the game? Plus, it's important to factor in what the family believes is in their child's best interest. There is no correct answer.

What complicates the ethical issues even more is when a mom looks at you and begs you not to give up hope on her child. I have heard about “maternal guilt” and, admittedly, don't know what that feels like. However, I certainly know what “doctor guilt” feels like.

You wish you had something that worked. You're hoping for a miracle just like the patient and their parents. But you see which direction this is going, based on lab tests, imaging results, and your experience.

You are praying and hoping, too. You do your best to try not to cry in front of the patient and their



**Nitya A. Narayan, MD,** is an assistant professor of pediatric hematology and oncology, Texas Children's Cancer & Hematology Centers, Baylor College of Medicine

family because they need someone who is composed and has a plan, not someone who is a crying mess (so you wait until you get to your car and you cry all the way home).

You understand they are angry, and they remark that they wish they had sought a second opinion. They wish you had told them they had only a few days to go (but you didn't think that was right, either, because you're only a human, not God, and the fact is, you were hopeful for more time, too).

You hear, in their voice, that they came to you for help and, despite your best efforts, you just couldn't deliver. That hurts as deeply as the kind of hurt of your worst broken heart—the one that leaves you a little broken forever because it never made sense to you. The same hurt as one where you still can't even walk by the exact spot you were when it happened, because it makes you sick.

The only word I have to describe how it feels when someone says they are excited about college, and you know they're likely not going, is sick. Or in another instance, they are not ready to die because their worry is, "But that means I won't see you guys at the hospital ever again." Or they plead with you to try something else (but there is nothing else).

We take care of many children with various problems, 2 of whom are currently the sickest kids I have ever seen in my entire career. Both with loving families, both who are just...sad. Who are we to strip people of their last hope? But on the other hand, is it fair to offer a solution that will have the same poor outcome, only with more suffering and less quality of life? Isn't it our moral obligation to tell the truth without trying to either give or take hope? Easier said than done. All these questions are obviously not meant to be answered, because there is not one correct solution, especially when no part of it is clear-cut. That's why they are ethical dilemmas.

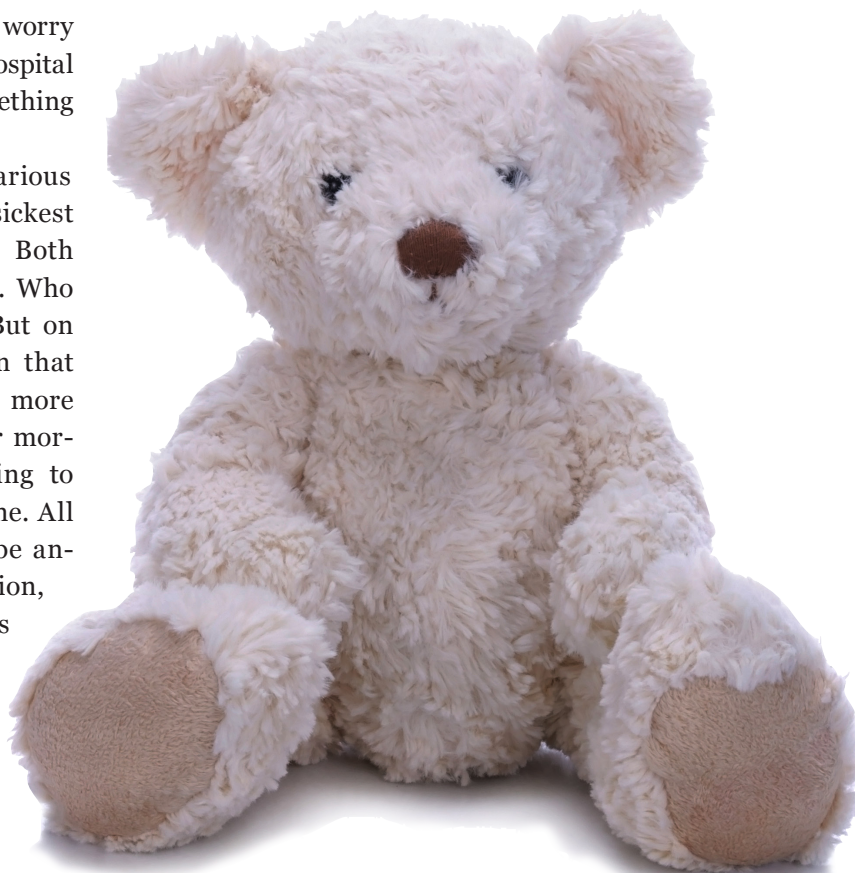
Like any other person, I feel grief. But I then have to turn around and walk into the next patient's room, as

the patient's doctor, not a grieving person, because they deserve the same care and my full attention, too.

The doctor guilt creeps right back in when well-meaning loved ones say things like "I don't know how you do it." You feel guilty because you didn't actually do much. You hope you did the medically and ethically responsible thing, but you didn't change the outcome for that person. Overall, I'm at the balance between being thankful that I'm not too jaded to feel nothing (if I ever get there, something is wrong with me) and, simultaneously, wanting to run.


I looked down today and realized my white coat pocket pretty accurately sums up my life in the past 2 weeks: a mangled, coffee-stained reference book, a stethoscope with a dinosaur that lights up, a full beeper, a Sheraton pen, and an emergency fork.

"Do no harm." Many times I do not know what that means after all. ■









# SURGERY IS NOT ALWAYS A SIMPLE DECISION

*By Shanel B. Bhagwandin, DO, MPH*

**A**s a surgical oncology fellow, I have had the privilege and the opportunity to treat patients afflicted with malignancies of different etiologies, mostly within the abdominal cavity. Variety is one of the primary reasons I was attracted to my specialty: On any given day, we perform a liver or pancreatic resection or an extremity sarcoma excision or deliver heated chemotherapy into the abdomen for advanced peritoneal malignancies.

My interests and training are solidified by the collaborative relationships we have with multiple specialties, such as medical oncology, radiation oncology, and therapeutic interventional radiologists. Through this complex approach to oncology care, I am challenged by the patients referred to us following a devastatingly new diagnosis of cancer with hopes of a cure. »



Shanel B. Bhagwandin, DO, MPH, is a complex general surgical oncology fellow at the Icahn School of Medicine at Mount Sinai

The breadth of surgical oncology introduces us to the wide spectrum of gastrointestinal malignancies, melanoma, sarcoma, etc. Within each specific cancer stage, I have learned that the biology of each cancer can be highly variable, and patients can recur having already received neoadjuvant or adjuvant chemoradiation as treatment for locoregional or distant metastasis. The personalization of cancer care is more elaborately expressed

in multidisciplinary tumor conferences and clinical trials.

The truth is, we don't have the answer yet. There isn't a magic pill, vaccination, or preventive treatment to get ahead of every type of cancer. The approach we most commonly advocate is behavior modification and screening modalities that detect cancer earlier, such as regular mammography or colonoscopy screenings. Often there are some tumors that present at such an advanced stage that surgery is no longer an option. It is difficult to present that reality to a patient who may very well still feel healthy, and knowing that disease progression is inevitable can quickly transition that conversation to focus on quality of life.

**Starting the Process: I'm Sorry We're Meeting Under These Circumstances**

When patients are referred to a surgical oncologist, there has been very little opportunity for them to accept a recent cancer diagnosis. The denial, the rationalization of blame, compounded by any attempt to explain to their loved ones what may be going on, is only about to become even more complicated. I firmly believe it's important to take a step

back, recognize there is a person in front of you, and address any obvious misconceptions before proceeding.

A reassuring interview tone versus one of judgment is a formidable foundation for trust in patient-physician communication. Being able to professionally address barriers to health literacy or delays in care is an important quality of any patient advocate. During my first few months of fellowship, I was dumbfounded by how long patient symptoms persisted without intervention, how physician-led work-ups spiraled, and how patients were inappropriately treated. It didn't take long for me to reflect on my training in public health to quickly recognize that the disparities among my patients were also a reflection of the inadequate referral patterns and poor follow-up in our healthcare system.

**You Can't See It All: Decisions for Surgery Are Complicated in Oncology**

Following any cancer diagnosis, patients understandably seek consultation and sometimes second or third opinions to see if they can undergo surgery to remove their cancer. A subtle distinction between surgical oncologists and other surgical specialties is our underlying training in oncology that marries the technical feasibility with an understanding of the biology of the disease.

There's nothing more disappointing than operating on a patient who recurs or presents with metastases on their 3-month surveillance imaging. It's unjustifiable, and surgery is not without considerable risks in these complicated cases. The psychological impetus for any patient is to "get the cancer out, now!" We commonly explain that certain aggressive cancers, albeit resectable, may benefit from treatment with chemotherapy or radiation up front instead of surgery. A treated cancer, which is now

smaller with regression from nearby vessels or lymph nodes, makes for a greater likelihood that the surgical oncologist will remove all visible disease. More important, it allows for earlier treatment of cancer cells that may have already escaped the operative field to distant organs, such as the liver and lungs. Without our being able to guarantee a treatment response with upfront chemotherapy, patients can also progress despite treatment, and the reality is that they probably would have suffered all the risks of surgery without any real benefit.

Every surgeon will occasionally make an emotional decision about whether to proceed with an operation because of a patient. The current recommendation for the majority of stage IV or metastatic cancers is typically ongoing chemotherapy or enrollment in a clinical trial. Surgery is offered infrequently in these situations, depending on the type of cancer. When a young patient presents with an advanced cancer, the heroic efforts of a surgeon or other treating physicians may conflict with the standard of care, particularly if that patient shows some degree of stability or treatment response despite the relative contraindication to surgery.

It is hard to truly know if the cancer has responded to the chemotherapy and whether that will correlate to some degree of improved survival. Furthermore, if surgery could potentially remove all the remaining viable disease, when is the appropriate time to proceed if we aim to maximize the benefit of chemotherapy that may be working? These cases are best discussed in the setting of a multidisciplinary conference among experts in that specific cancer to determine a reasonable option. It's important to anticipate the expectations of patients and their families preoperatively. Developing such an aggressive malignancy at a younger age increases the likelihood that the

cancer will inevitably recur or progress despite our best efforts (patients included).

### **The Patient Variable**

I have learned not to try to prognosticate a diagnosis prior to understanding more about a patient's cancer. It is inherent that when patients learn that they have cancer, they immediately want to know how "bad" it is. Not all cancers behave the same, nor will they respond the same to treatment. There are some cases of metastatic cancer that the patient will inevitably succumb to. It is important to discuss the likelihood of that happening if there is a valid argument regarding whether any treatment should be prescribed considering severe comorbidities and decompensation.

At the same time, assessing the appropriate stage of cancer is more accurately done following surgery, and that can allow for additional information to be shared with the patient about their prognosis. It has been shown multiple times in the literature that patients don't retain much about a conversation regarding their prognosis, and I tend to defer it until the postoperative visit, when the cancer has been pathologically staged.

In certain cases, what I do offer is that most patients are typically unresectable at the time of diagnosis of "X" cancer, and the fact that we're able to proceed to the operating room is optimistic. Whereas most medical or surgical oncologists will provide prognostic information to the patient as a median variable, most patients will take that as an absolute number. The addition of a best-case, worst-case, and most-likely case scenario is a strategy that addresses the perception of that patient's survival. A best-case scenario also preserves hope without being overly optimistic, and it has been my observation that patients appreciate knowing that certain difficult life decisions need not be undertaken if they can wait. ■



# The Young SIOG Interest Group: Developing Geriatric Oncologists of the Future

*By Kah Poh Loh, MB, BCh, BAO*

*James P. Wilmot Cancer Institute, University of Rochester School of Medicine and Dentistry*

*Nicolò Battisti, MD, PhD*

*Breast Unit, The Royal Marsden NHS Foundation Trust*

*Manuel Rodrigues, MD, MSc*

*Department of Medical Oncology, Institut Curie, PSL Research University*

*Mandy Kiderlen, MD*

*Department of Internal Medicine, Leiden University Medical Center*

*Tina Hsu MD, FRCPC, ABIM*

*The Ottawa Hospital Cancer Centre, University of Ottawa*

*Capucine Baldini, MD*

*Drug Development Department, Gustave Roussy Cancer Campus*

*Nienke de Glas, MD, PhD<sup>4</sup>*

*Department of Internal Medicine, Leiden University Medical Center  
on behalf of Young SIOG Interest Group*

**C**ancer is a disease that is associated with aging. Within the older population, most cancer incidence occurs in geriatric individuals (aged 65 and older). Decision making and caring for older adults is often more complex because of the presence of comorbid conditions, polypharmacy, and a higher likelihood of frailty. Furthermore, older adults are often understudied compared with their younger counterparts. There is currently an unmet need to improve cancer care in this population. The International Society of Geriatric Oncology (SIOG) was founded in 2000 with a goal of fostering the development of healthcare professionals in geriatric oncology through education, clinical practice, and research. »

The Young SIOG Interest Group was established in 2013 with 3 main goals:

- 1) Improve education in research and clinical practice for young researchers and clinicians in all disciplines that deal with treatment of older cancer patients.
- 2) Establish a network of young researchers and clinicians in the geriatric oncology field.
- 3) Create a platform of young researchers and facilitate mentorship.

This group is currently composed of 8 members from the United States, Canada, the Netherlands, France, Italy, the United Kingdom, and Malaysia. The group meets annually at the SIOG annual meeting. In addition, 3 to 4 additional conference calls are held to discuss issues related to young trainees in geriatric oncology and to address identified gaps in care.

### **SIOG Annual Meeting**

The 16th annual SIOG meeting was held November 17 to 19, 2016, in Milan, Italy. The annual meeting serves as an ideal venue for trainees interested in geriatric oncology to meet with international experts in the field. The Young SIOG group organized several events aimed at trainees during the conference. The Young SIOG Mentorship session featured Tanya M. Wildes, MD, MSCI, and Pierre Soubeyran, MD, PhD, who provided guidance on undertaking research studies in older adults. Holly M. Holmes, MD, MS,

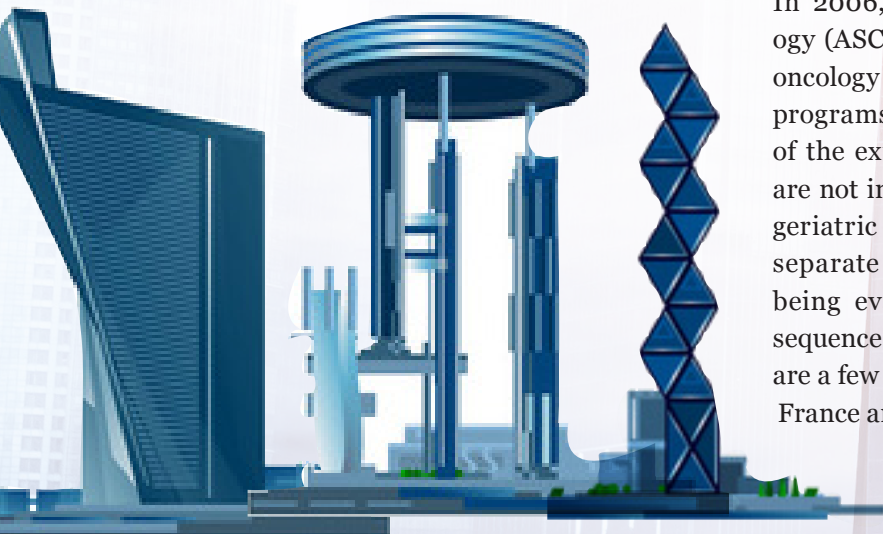
offered her insights into job exploration, and Armin Shahrokni, MD, MPH, a practicing geriatrician and oncologist, discussed connecting the 2 specialties to provide better care to older adults with cancer.

This year the Young SIOG Interest Group also organized a poster walk led by Arti Hurria, MD and Demetris Papamichael, MD; the walk was well attended by trainees. Topics discussed included the feasibility of implementing geriatric assessment-targeted interventions, outcomes of older adults participating in clinical trials, and healthcare in end-of-life care among older patients with lung cancer.

Trainees also gathered during the Young SIOG plenary session, which served as a forum for trainees to express and share their ideas, thoughts, and challenges in the field of geriatric oncology. The highlight of the trainee events was the Young Investigator Award presentations given by Zachary D. Horne, MD, in radiation oncology, Melissa Loh, MD, BCh, BAO, in medical oncology, and Suzanne Stokmans, MD, in surgical oncology. Dr Horne discussed patterns of care and outcomes in older patients with oropharyngeal cancer; Dr Loh discussed the high prevalence of sleep disturbance with depression, fatigue, and pain in older patients with cancer; and Dr Stokmans discussed the outcomes of older patients with cancer who underwent surgery.

### **Geriatric Oncology Training and Education Programs**

In 2006, the American Society of Clinical Oncology (ASCO) Hartford Foundation funded 10 geriatric oncology training programs. However, some of these programs have since been discontinued, and many of the existing geriatric oncology training programs are not integrated. For example, in the United States, geriatric and oncology fellowships usually require separate application processes, with candidates being evaluated on a case-by-case basis, and the sequence of the training is variable. In Europe, there are a few established formal training opportunities, in France and Italy.



Understanding that geriatric oncology programs can be heterogeneous, the Young SIOG committee established geriatric oncology programs in the United States, Canada, Asia, and Europe ([siog.org/content/geriatric-oncology-educational-centers](http://siog.org/content/geriatric-oncology-educational-centers)) to assist future applicants when seeking programs. In the upcoming years, information about training opportunities on other continents will also be available.

In 2016, SIOG also organized the third edition of the Advanced Course in Geriatric Oncology in Treviso, Italy, from June 29 to July 2, which was attended by 35 students from 18 different countries ([siog.org/content/siog-2016-advanced-course-treviso-italy-0#about](http://siog.org/content/siog-2016-advanced-course-treviso-italy-0#about)). This course aims to train professionals in the management of older patients with cancer, providing specific skills in assessment, care pathways, and therapeutic choices for this population. The goal is to develop the general principles of both geriatric medicine and oncology that are useful in treating older patients with cancer. The course is delivered using case-based programs, discussions, and debates led by renowned international geriatric oncology experts. The 2017 Advanced Course also recently took place on June 28 to July 1 in Treviso, Italy.

### **SIOG Task Forces**

A number of SIOG task forces have been established and are responsible for producing guidelines in the field of geriatric oncology. To allow a deeper understanding of how guidelines are developed, 1 young trainee is invited to be part of each task force. As part of this, Young SIOG Interest Group members are also provided the opportunity to interact with senior members, to participate in review and synthesis of the literature, and to formulate guidelines (for example, Nienke de Glas, MD, PhD, a Young SIOG member, is part of the task force on anti-HER2 targeted treatments in elderly patients with breast cancer). All the guidelines are

presented at the SIOG annual meetings and are eventually published in peer-reviewed journals.

### **Social Media**

To encourage a networking platform outside the annual meeting, both the Young SIOG Facebook ([facebook.com/groups/YoungSIOG/](https://facebook.com/groups/YoungSIOG/)) and LinkedIn ([linkedin.com/groups/7460417](https://linkedin.com/groups/7460417)) pages were created. At the time of this writing, there were 48 and 80 members, respectively. The social media groups provide forums for discussion about geriatric oncology-related issues as well as peer-reviewed journal articles. Given that most Young SIOG members work at institutions that have few or no geriatric oncologists, these groups also serve as venues for members to exchange ideas, share knowledge, and provide guidance to one another. In the past 2 years, a survey was distributed to gather feedback from members to help refine the group's activities. Further, the committee members also use sites for announcements of trainee activities and opportunities.

### **Future Directions**

Currently, the Young SIOG committee members are working on facilitating funding for training and research opportunities in geriatric oncology. The goal is to encourage trainees to participate in this field and eventually to pursue a career in geriatric oncology. The Young SIOG committee members will also continue to advocate and increase the awareness of geriatric oncology, such as working with other societies including ASCO and the European Society Medical Oncology trainee councils, as well as the Junior Cancer and Aging Research Group. The Young SIOG's vision is to establish a network of young researchers to facilitate future collaborations.

Geriatric oncology is no longer a niche, and all adult oncologists and geriatricians should familiarize themselves with assessing and managing older adults with cancer. We, as the Young SIOG members, are excited to be part of this growing field. ■

# Residents in Appalachia Face Higher Cancer Incidence

By Ariela Katz

The Appalachian region stretches across 420 counties in 13 states, from New York to Mississippi, and is known to have higher cancer incident rates (IRs) in many disease categories compared with the non-Appalachian United States. Although the IR gap between Appalachia and non-Appalachia has been narrowing over the years, statistically significant differences persist in 22 tumor types.

Investigators evaluated IRs in Appalachia from 2004 to 2011 and compared those with IRs in non-Appalachian regions (Table). They found that in Appalachia, patients with cancer were primarily white (92%) and non-Hispanic (99%), with more of those cases clustered in areas with lower economic status. Elevated rates of tobacco-related cancers were particularly apparent for both men and women in Appalachia, whereas prostate cancer IRs were lower and hematological IRs were roughly equivalent with IRs in the non-Appalachian United States. ■

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Wilson RJ, Ryerson AB, Singh SD, King JB. Cancer incidence in Appalachia, 2004-2011. *Cancer Epidemiol Biomarkers Prev.* 2016;25(2):250-258. doi: 10.1158/1055-9965.EPI-15-0946.

Table 1. Cancer Incidence Rates in Appalachia Versus Non-Appalachia per 100,000 Residents, 2004-2011\*

Tumor site	Appalachian Region		Non-Appalachian US	
	Male	Female	Male	Female
All site	565.8	428.7	543.0	418.2
Oral cavity and pharynx	17.8	6.4	16.5	6.2
Esophagus	9.0	1.7	8.5	1.9
Stomach	9.0	4.2	9.5	4.7
Colon and rectum	56.6	41.8	52.4	39.5
Liver and intrahepatic bile duct	8.4	2.8	10.7	3.6
Pancreas	13.5	10.3	13.7	10.7
Larynx	8.2	2.0	6.6	1.4
Lung and bronchus	100.4	61.0	79.5	54.7
Melanoma of the skin	27.4	19.1	27.4	17.8
Breast	—	145.2	—	153.0
Breast invasive	—	118.2	—	122.4
Breast in situ	—	27.0	—	30.5
Cervix uteri	—	8.3	—	7.9
Corpus and uterus	—	25.2	—	24.5
Ovary	—	12.7	—	12.3
Prostate	139.9	—	147.0	—
Testis	5.5	—	5.5	—
Urinary bladder	39.8	9.7	37.0	9.3
Kidney and renal pelvis	21.2	11.7	21.1	11.0
Brain and other nervous system	8.3	6.1	7.9	5.7
Thyroid	6.3	19.2	6.0	17.7
Hodgkin lymphoma	3.1	2.5	3.2	2.5
Non-Hodgkin lymphoma	23.3	16.4	23.4	16.3
Myeloma	7.3	4.7	7.5	4.9
Leukemia	16.9	10.4	16.7	10.2

\*Statistically significant differences in bold.

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# Web-Based Therapy Helps Newly Diagnosed Patients Manage Stress

By Anita T. Shaffer

Newly diagnosed patients with cancer experienced improvements in quality of life (QoL) and lower levels of distress by participating in a web-based stress management program, according to results of a study presented at the 2017 ASCO Annual Meeting.

The randomized study demonstrated that most of the participants reported feeling distressed at baseline and that a structured online program guided by psychologists was an effective method of offering them assistance, researchers said when discussing the findings during a press cast.

“Our online stress management program was feasible with newly diagnosed cancer patients during active treatment,” said lead study author Viviane Hess, MD, a medical oncologist at the University Hospital of Basel in Switzerland. “At baseline, 3 of 4 patients were distressed, so we reached a target population in need of support.”

Oncologists and psychologists designed the STREAM program as an intervention that covers 8 weekly topics such as bodily reaction to stress, cognitive stress reduction, feelings, and social interactions. For each topic, participants receive written and audio information and complete exercises and questionnaires. Psychologists review patients’ feedback weekly and offer written guidance and support through a secure online portal; patients can then respond in writing.

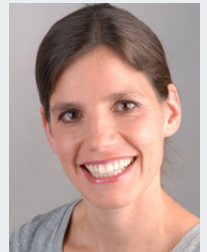
To test the STREAM program, 129 patients newly diagnosed with cancer were randomized within 12 weeks of starting anticancer treatment to an immediate intervention (n = 64) or to a control group who would have access to the program after a 2-month period (n = 65).

Investigators measured QoL using the Functional Assessment in Cancer Therapy-Fatigue (FACIT-F) scale, psychological distress with the Distress Thermometer (DT), and anxiety and depression with the Hospital Anxiety and Depression Scale (HADS).

They found patients who participated in the program had significantly improved QoL, with FACIT-F scores that averaged 8.59 points higher (range, 2.45-14.73;  $P = .007$ ). Similarly, those who received intervention had a greater improvement in distress, with an average 0.85 decline on the DT scale (range, -1.60 to -0.10;  $P = .03$ ). Anxiety and depression also declined for the intervention group by 1.28 points (range, -3.02 to 0.45), but this was not statistically significant ( $P = .15$ ).

Hess said the findings support the use of remote technologies. “I think online psychological support will be much more important in the years to come, as the digital generation reaches the age when they are at higher risk of cancer. For them, it will be natural to use such online tools and communicate without face-to-face interaction, and so now is the time to standardize and validate the tools,” she said.

Researchers plan to translate the STREAM program, which is currently available only in German, into other languages. ■



Viviane Hess, MD,  
Medical Oncologist  
University Hospital of  
Basel in Switzerland

# 2017/2018 Oncology & Hematology Meetings



**October 6-7, 2017**

**National Comprehensive Cancer Network (NCCN) 12th Annual Congress: Hematologic Malignancies**  
San Francisco, CA  
[goo.gl/rK3bBW](http://goo.gl/rK3bBW)

**October 12-15, 2017**

**European School of Haematology (ESH) 19th Annual John Goldman Conference on Chronic Myeloid Leukemia**  
Estoril, Portugal  
[goo.gl/x8dNuP](http://goo.gl/x8dNuP)

**October 20-21, 2017**

**PER® 2nd Annual European Congress on Hematology™: Focus on Lymphoid Malignancies**  
Paris, France  
[gotoper.com/link/2609](http://gotoper.com/link/2609)

**November 2-3, 2017**

**10th International Congress on Myeloproliferative Neoplasms and Chronic Myeloid Leukemia**  
New York, NY  
[goo.gl/AZq3e4](http://goo.gl/AZq3e4)

**November 8-10, 2017**

**PER® 35th Annual Chemotherapy Foundation Symposium (CFS)**  
New York, NY  
[gotoper.com/link/2610](http://gotoper.com/link/2610)

**November 8-12, 2017**

**Society for Immunotherapy of Cancer (SITC) 32nd Annual Meeting**  
National Harbor, MD  
[goo.gl/Njsc2H](http://goo.gl/Njsc2H)

**November 11, 2017**

**PER® 12th Annual New York Lung Cancer Symposium®**  
New York, NY  
[gotoper.com/link/2595](http://gotoper.com/link/2595)

**November 29–December 1, 2017**

**18th Annual Meeting of the Society of Urologic Oncology (SUO)**  
Washington, DC  
[goo.gl/ErKodb](http://goo.gl/ErKodb)

**December 5-9, 2017**

**40th Annual San Antonio Breast Cancer Symposium (SABCS)**  
San Antonio, TX  
[goo.gl/Sr9FmW](http://goo.gl/Sr9FmW)

**December 9-12, 2017**

**59th American Society of Hematology (ASH) Annual Meeting**  
Atlanta, GA  
[goo.gl/mtek18](http://goo.gl/mtek18)

**December 16, 2017**

**PER® 2nd Annual International Congress on Immunotherapies in Cancer™: Focus on Practice-Changing Application**  
New York, NY  
[gotoper.com/link/2596](http://gotoper.com/link/2596)

**January 18-20, 2018**

**2018 Gastrointestinal Cancers Symposium: Multidisciplinary Care: Local Practice, Global Outcomes**  
San Francisco, CA  
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- **A Word From Your Fellows:** articles written by current fellows describing their thoughts and opinions on various topics.
- **Transitions:** articles written by oncology professionals that provide career-related insight and advice to fellows on life, post training.
- **A Day in the Life:** articles describing a typical workday for a fellow or an oncology professional, post training.

The list above is not comprehensive; suggestions for future topics are welcome. Please note that we have the ability to edit and proofread submitted articles and that all manuscripts will be sent to the author for final approval prior to publication.



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If you are interested in contributing an article to ***Oncology Fellows*** or would like more information, please e-mail Ariela Katz at [akatz@onclive.com](mailto:akatz@onclive.com).

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